2017 Medicare PPO Plans for Erie County

TYPE OF MEDICAL SERVICE	ORIGINAL MEDICARE	MVP Healthcare 1-888-280-6205		Independent Health (716)635-4900				BlueCross/BlueShield 1-800-248-9296			
		Well Select with Part D		Medicare Passport Advantage PPO		Forever Blue PPO Focus		Forever Blue PPO Value		Forever Blue PPO 751	
PREMIUMS	**$121.80**	**$59.10**		**$128**		**$78**		**$111**		**$198**	
Deductible	$166	$0		$500		$0		$0		$0	
		IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
PCP Visits	20%**	$15	$60	$20	$40	$30	35%	$20	35%	$10	25%
Wellness Exam	$0	$0	$0	$0	30%	$0	$0	$0	$0	$0	$0
Specialty Visits	20%**	$50	$60	$35	$40	$50	35%	$40	35%	$30	25%
Outpatient Mental Health	20%	$40	$60	$40	45%	$40	50%	$40	50%	$40	50%
Outpatient Substance Abuse	20%**	$50	$60	45%	45%	50%	50%	50%	50%	50%	50%
Outpatient Surgery	20%**	$300/$600	40%	$250	30%	$275/$325	35%	$250/$300	35%	$225/$275	25%
Emergency Care	20%**	$75	$75	$75	$75	$75	$75	$75	$75	$75	$75
Urgent Care	20%**	$60	$60	$65	$65	$65	$65	$65	$65	$65	$65
Ambulance Services	20%**	$200	$200	$200	$200	$250	$250	$250	$250	$125	$125
Durable Medical Equipment	20% Medicare Approved	20%	40%	20%	50%	20%	50%	20%	50%	20%	50%
Prosthetic Devices	20%	20%	40%	20%	50%	20%	50%	20%	50%	20%	50%
Cardiac Rehab	20%	36session=$50	Not Covered	36sessions=$0	36sessions=30%	$15	35%	$15	35%	$15	25%
X-Rays	20%**	$60	$60	$35	50%	$50	35%	$50	35%	$40	25%
Diagnostic Services	20%	$20-20%	40%	$75	50%	$150	35%	$150	35%	$75	25%
Lab Services	$0	$20	40%	$0	30%	$5	35%	$5	35%	$5	25%
Radiation Therapy	20%	20%	40%	20%	50%	$50	35%	$50	35%	$40	25%
Chiropractic Care	limited coverage 20%**	$20	Not Covered	$20	50%	$20	35%	$20	35%	$20	25%
Medically Necessary Foot Care	20%** (medical limits apply)	$50	$60	$250	30%	$50	35%	$40	35%	$30	25%
Routine Foot Care	Not Covered	$50	$60	$35	$40	$50	35%	$40	35%	$30	25%
P.T., O.T. and Speech Therapy	20%**	$40	$60	$15	30%	$25	35%	$25	35%	$25	25%
Inpatient Hospital	$1,280 deductible	$450/day days 1-4 $0/day days 5+	40%	$250/day days 1-7 $0/day days 8+	30%	$270/day days 1-7 $0/day days 8+	35%	$250/day days 1-7 $0/day days 8+	35%	$205/day days 1-7 $0/day days 8+	30%
Inpatient Mental Health*	$1,280 deductible	$315/day days 1-5 $0/day days 6+	40%	$250/day days 1-6 $0/day days 7+	30%	$260/day days 1-6 $0/day days 7+	35%	$260/day days 1-6 $0/day days 7+	35%	$260/day days 1-6 $0/day days 7+	30%

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		Well Select with Part D		**Medicare Passport Advantage PPO**		**Forever Blue PPO Focus**		**Forever Blue PPO Value**		**Forever Blue PPO 751**	
PREMIUMS	$121.80	**$59.10**		**$128**		**$78**		**$111**		**$198**	
Deductible	$166.00	$0		$500		$0		$0		$0	
		IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Skilled Nursing Facility	$0/day days 1-20 $161/day days 21-100	$0/day days 1-20 $160/day days 21-100	40%	$0/day days 1-20 $75/day days 21-100	30%	$0/day days 1-20 $164.50/day days 21-100	35%	$0/day days 1-20 $164.50/day days 21-100	35%	$0/day days 1-20 $164.50/day days 21-100	30%
Home Health Care	$0	$0	40%	$0	30%	$0	35%	$0	35%	$0	25%
Mammograms	$0	$0	$0	$0	$0	$0	35%	$0	35%	$0	25%
Bone Mass Measurment	$0	$0	$0	$0	$0	$0	35%	$0	35%	$0	25%
Colorectal Screening	$0	$0	$0	$0	$0	$0	35%	$0	35%	$0	25%
Flu, Pneumonia & Hepatitis B	$0	$0	$0	$0	$0	$0	35%	$0	35%	$0	25%
Dialysis	20%	20%	20%	10%	10%	$10	$10/20%	$10	$10/20%	$10	$10/20%
Prescription Drugs	20% Part B Covered only No Part D	Copays $1/$11/$47/50%/ 25%, $400 Deductible, 20%-Part B Drugs	40%-Part B Drugs	Copays $4/$12/$45/45%/ 33%, No Deductible, 20%-Part B Drugs	Copays $4/$12/$45/45%/ 33%, No Deductible, 30%-Part B Drugs	Copays $10/$15/$42/$94/ 33%, No Deductible, 20%-Part B Drugs	Copays $10/$15/$42/$94/ 33%, No Deductible, 35%-Part B Drugs	Copays $7/$15/$42/$94/ 33%, No Deductible, 20%-Part B Drugs	Copays $7/$15/$42/ $94/33%, No Deductible, 35%-Part B Drugs	Copays $5/$15/$42/$94/ 33%, No Deductible, 20%-Part B Drugs	Copays $5/$15/$42/$94/ 33%, No Deductible, 25%-Part B Drugs
Vision Services	20% + for 1 pair glasses/ frames/contact lens after cataract surgery 20% + coverage for retinopathy exam 1 per year for diabetics	$50 Eye Exam 20% Post-cataract Surgery Eyewear	$60 Eye Exam 40% Post-cataract Surgery Eyewear	$20 Eye Exam $150/yr Eyeglasses Allowance	$35 Eye Exam Re-imbursement $150/yr Eyeglasses Allowance	$50 Eye Exam $100/yr Eyeglasses Allowance	35% Eye Exam $100/yr Eyeglasses Allowance	$40 Eye Exam $100/yr Eyeglasses Allowance	35% Eye Exam $100/yr Eyeglasses Allowance	$30 Eye Exam $100/yr Eyeglasses Allowance	25% Eye Exam $100/yr Eyeglasses Allowance
Hearing Services	20%**	$50 Exam, $699-$999 per aid/per year	$60 Exam,100% aids	$20/$35 Exam; $699-$999 per aid/per year	30% Exam, $699-$999 per aid/per year	$45/$50 Exam, $699-$999 per aid/per year	$45/35% Exam, $699-$999 per aid/per year	$40/$45 Exam, $699-$999 per aid/per year	$45/35% Exam, $699-$999 per aid/per year	$30/$45 Exam, $699-$999 per aid/per year	$45/25% Exam, $699-$999 per aid/per year
Diabetic Training and Supplies	20%	20%	40%	Training $0, Supplies $10	Training 30%, Supplies 30%	$0	50%	$0	50%	$0	50%
Dental Coverage	limited coverage 20%**	Not Covered	Not Covered	$20: 2 routine cleanings, exams & bitewing x-rays/yr; full mouth/every 3yrs	50%: 2 routine cleanings, exams & bitewing x-rays/yr; full mouth/every 3 yrs	Not Covered * Optional Dental Coverage	Not Covered * Optional Dental Coverage	Not Covered * Optional Dental Coverage	Not Covered * Optional Dental Coverage	Not Covered * Optional Dental Coverage	Not Covered * Optional Dental Coverage
Max out of Pocket		$6,700	$10,000	$6,700	$10,000	$6,700	$10,000	$6,700	$10,000	$6,700	$10,000
Full LIS		$29.40		$87		$37		$70		$157	
Full LIS & EPIC		$29.40		$46		$37		$70		$157	

2017 Medicare PPO Plans for Erie County

TYPE OF MEDICAL SERVICE	ORIGINAL MEDICARE	United Healthcare Medicare Complete Choice 1-800-555-5757								Today's Options 1-866-249-8668			
		Plan 1		Plan 3		Plan 4		Essential No RX		Advantage Plus 150A		Advantage Plus 550B	
PREMIUMS	**$121.80**	**$0**		**$36**		**$66**		**$0**		**$97**		**$39**	
Deductible	$166	$0		$0		$0		$0		$0		$0	
		IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
PCP Visits	20%**	$10	$50	$5	$50	$0	$50	$10	$50	$0	$10	$10	$25
Wellness Exam	$0	$0	40%	$0	40%	$0	40%	$0	40%	$0	25%	$0	25%
Specialty Visits	20%**	$45	$75	$30	$75	$25	$75	$45	$75	$25	$35	$35	$60
Outpatient Mental Health	20%	$30/$40	$35/$45	$30/$40	$35/$45	$30/$40	$35/$45	$30/$40	$35/$45	$30	25%	$40	25%
Outpatient Substance Abuse	20%**	$30/$40	$35/$45	$30/$40	$35/$45	$30/$40	$35/$45	$30/$40	$35/$45	$30	25%	$40	25%
Outpatient Surgery	20%**	20%	40%	$295	40%	$250	40%	20%	40%	$75-$150	25%	$250-$300	25%
Emergency Care	20%**	$75	$75	$75	$75	$75	$75	$75	$75	$75	20% Worldwide Coverage	$75	20% Worldwide Coverage
Urgent Care	20%**	$30-$40	$30-$40	$30-$40	$30-$40	$25-$40	$25-$40	$30-$40	$30-$40	$35	$35	$35	$35
Ambulance Services	20%**	$250	$250	$250	$250	$250	$250	$250	$250	$300	$300	$300	$300
Durable Medical Equipment	20% Medicare Approved	20%	50%	20%	50%	20%	50%	20%	50%	20%	25%	20%	25%
Prosthetic Devices	20%	20%	40%	20%	40%	20%	40%	20%	40%	20%	25%	20%	25%
Cardiac Rehab	20%	$20	40%	$20	40%	$20	40%	$20	40%	$15	25%	$40	25%
X-Rays	20%**	$11	$16	$14	$21	$14	$21	$14	$21	$15	25%	$15	25%
Diagnostic Services	20%	20%	40%	20%	40%	20%	40%	20%	40%	20%	25%	20%	25%
Lab Services	$0	$10	$10	$10	$10	$10	$10	$10	$10	$0	25%	$0	25%
Radiation Therapy	20%	20%	40%	20%	40%	20%	40%	20%	40%	20%	25%	20%	25%
Chiropractic Care	limited coverage 20%**	$20	$75	$20	$75	$20	$75	$20	$75	$20	25%	$20	25%
Medically Necessary Foot Care	20%** (medical limits apply)	$45	$75	$30	$75	$25	$75	$45	$75	$35-limitations	25%-limitations	$50-limitations	25%-limitations
Routine Foot Care	not covered	6visits/yr=$45ea	6visits/yr=$75ea	6visits/yr=$30ea	6visits/yr= $75ea	6visits/yr=$25ea	6visits/yr=$75ea	6visits/yr=$45ea	6visits/yr=$75ea	$35	25%	$50	25%
P.T., O.T. and Speech Therapy	20%**	$40	$75	$30	$75	$25	$75	$40	$75	$15	25%	$40	25%
Inpatient Hospital	$1260 Deductible	$395/day days 1-4 $0/day days 5+	$500/day days 1-20 $0/day days 21+	$325/day days 1-4 $0/day days 5+	$500/day days 1-20 $0/day days 21+	$295/day days 1-4 $0/day days 5+	$500/day days 1-20 $0/day days 21+	$395/day days 1-4 $0/day days 5+	$500/day days 1-20 $0/day days 21+	$450	$250/day days 1-7 $0/day days 8-90	$295/day days 1-5; $0/day days 6-90	$300/day days 1-7 $0/day days 8-90
Inpatient Mental Health*	$1260 Deductible	$395/day days 1-4 $0/day days 5-90	$500/day days 1-20 $0/day days 21-90	$325/day days 1-4 $0/day days 5-90	$500/day days 1-20 $0/day days 21-90	$295/day days 1-4 $0/day days 5-90	$500/day days 1-20 $0/day days 21-90	$395/day days 1-4 $0/day days 5-90	$500/day days 1-20 $0/day days 21-90	$450	$250/day days 1-7 $0/day days 8-90	$295/day days 1-5 $0/day days 6-90	$300/day days 1-7 $0/day days 8-90

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TYPE OF MEDICAL SERVICE	**ORIGINAL MEDICARE**	**United Healthcare Medicare Complete Choice 1-800-555-5757**								**Today's Options 1-866-249-8668**			
		Plan 1		**Plan 3**		**Plan 4**		**Essential No RX**		**Advantage Plus 150A**		**Advantage Plus 550B**	
PREMIUMS	$121.80	**$0**		**$36**		**$66**		**$0**		**$97**		**$39**	
Deductible	$166	$0		$0		$0		$0		$0		$0	
		IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Skilled Nursing Facility	Days 1-20 $0 Days 21-100 $161/day	$0/day days 1-20 $160/day days 21-62 $0/day days 63-100	$250/day days 1-40 $0/day days 41-100	$0/day days 1-20 $160/day days 21-57 $0/day days 58-100	$250/day days 1-40 $0/day days 41-100	$0/day days 1-20 $160/day days 21-54 $0/day days 55-100	$250/day days 1-40 $0/day days 41-100	$0/day days 1-20 $160/day days 21-62 $0/day days 63-100	$250/day days 1-40 $0/day days 41-100	$0/day days 1-20 $75/day days 21-100	$0/day days 1-20 $150/day days 21-100	$0/day days 1-20 $150/day days 21-100	$0/day days 1-20 $200/day days 21-100
Home Health Care	$0	$0	50%	$0	50%	$0	50%	$0	50%	$0	25%	$0	25%
Mammograms	$0	$0	$0-40%	$0	$0-40%	$0	$0-40%	$0	$0-40%	$0	25%	$0	25%
Bone Mass Measurment	$0	$0	$0-40%	$0	$0-40%	$0	$0-40%	$0	$0-40%	$0	25%	$0	25%
Colorectal Screening	$0	$0	$0-40%	$0	$0-40%	$0	$0-40%	$0	$0-40%	$0	25%	$0	25%
Flu, Pneumonia & Hepatitis B	$0	$0	$0-40%	$0	$0-40%	$0	$0-40%	$0	$0-40%	$0	25%	$0	25%
Dialysis	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	25%	20%	25%
Prescription Drugs	20% Part B Covered only No Part D	Copays $2/$12/$47/$100/ 27%, $290 Deductible Tiers 3-5, 20%-Part B Drugs	Copays $2/$12/$47/$100/ 27%, $290 Deductible Tiers 3-5, 40%-Part B Drugs	Copays $2/$8/$45/$95/ 30%, $150 Deductible Tiers 3-5, 20%-Part B Drugs	Copays $2/$8/$45/$95 /30%, $150 Deductible Tiers 3-5, 40%-Part B Drugs	Copays $2/$8/$45/$95/ 33%, No Deductible, 20%-Part B Drugs	Copays $2/$8/$45/$95/ 33%, No Deductible, 40%-Part B Drugs	Part D=not covered; Part B=20%	Part D=not covered; Part B=40%	Copays $0/$5/$35/$75/ 33%, No Deductible, 20%-Part B Drugs	Copays $0/$5/$35/$75/ 33%, No Deductible, 25%-Part B Drugs	Copays $2/$7/$37/$90/ 33%, No Deductible, 20%-Part B Drugs	Copays $2/$7/$37/$90/33 3%, No Deductible, 25%-Part B Drugs
Vision Services	20% + for 1 pair glasses/ frames/contact lens after cataract surgery 20% + coverage for retinopathy exam 1 per year for diabetics	$20 Eye Exam $0 Post-cataract Surgery Eyewear	$45 Eye Exam 40% Post-cataract Surgery Eyewear	$20 Eye Exam $0 Post-cataract Surgery Eyewear	$75 Eye Exam 40% Post-cataract Surgery Eyewear	$20 Eye Exam $0 Post-cataract Surgery Eyewear	$75 Eye Exam 40% Post-cataract Surgery Eyewear	$20 Eye Exam $0 Post-cataract Surgery Eyewear	$75 Eye Exam 40% Post-cataract Surgery Eyewear	$0 Eye Exam $20 Post-cataract Surgery Eyewear	25% Eye Exam 25% Post-cataract Surgery Eyewear	$0 Eye Exam $20 Post-cataract Surgery Eyewear	25% Eye Exam 25% Post-cataract Surgery Eyewear
Hearing Services	20%**	Exam=$10;2aids/yr= $330-$380ea	Exam=$75;2aids/yr= $330-$380ea	Exam=$5;2aids/yr= $330-$380ea	Exam=$75;2aids/ yr= $330-$380ea	Exam=$0;2aids/yr = $330-$380ea	Exam=$75;2aids/yr = $330-$380ea	Exam=$10;2aids/y r= $330-$380ea	Exam=$75;2aids/ yr= $330-$380ea	$20	25%	$20	25%
Diabetic Training and Supplies	20%	$0-20%	40%	$0-20%	40%	$0-20%	40%	$0-20%	40%	0-20%	25%	0-20%	25%
Dental Coverage	limited coverage 20%**	Not Covered * Optional Dental Coverage	Not Covered * Optional Dental Coverage	Not Covered * Optional Dental Coverage	Not Covered * Optional Dental Coverage	Preventive or covered=$0 up to $1000/yr	Preventive or covered=$0 up to $1000/yr	Not Covered * Optional Dental Coverage	Not Covered * Optional Dental Coverage	Comprehensive	Comprehensive	Comprehensive	Comprehensive
Max out of Pocket		$6,700	$10,000	$5,900	$10,000	$5,400	$10,000	$6,700	$10,000	$3,400	$3,400	$6,700	6,700
Full LIS		$0		$12.90		$42.30		No RX					
Full LIS & EPIC		$0		$12.90		$42.30		No RX					